5101:3-2-078 Redetermination of prospective payment rates.

(A) General description.

In future years, prospective payment rates may be determined by application of a projected inflation value as set forth in paragraph (B) of this rule leaving base-year costs and relative weights unchanged. Alternatively, through revision of relevant rules in this chapter, either or both the rebasing of base-year costs or the recalibration of relative weights for DRGs may occur and may result in a significant change in the prospective payment rate. In addition to redetermination of rates associated with the beginning of a new rate year, redetermination may occur within a rate year. At the beginning of each new rate year, a ninety-day period will be provided to both the department and the hospitals for the verification of all data used in rate calculations and the detection of errors in the calculations of rate amounts following the methodologies detailed in rules 5101:3-2-074 to 5101:3-2-077 of the Administrative Code. Rule 5101:3-2-0712 of the Administrative Code describes the procedures by which a hospital may request reconsideration of a rate component during the first ninety days of a rate year as well as the conditions under which subsequent reconsideration may be requested. Rule 5101:3-2-24 of the Administrative Code describes the conditions under which the department may initiate rate adjustments after the initial ninety-day verification period has passed. This rule describes the applicability of and procedures for redetermination of prospective rates.

(B) Application of inflation allowance.

At the start of each succeeding state fiscal year, the department shall apply a projected inflation value as defined in rule 5101:3-2-074 of the Administrative Code. ~~, unless rebasing and/or recalibration is performed as identified in paragraph (A) of this rule.~~

(C) Redetermination of peer group average cost per discharge component of the prospective payment rate.

The peer group average cost per discharge component described in paragraphs (E)(1) to (E)(4) of rule 5101:3-2-074 of the Administrative Code may be redetermined in accordance with paragraphs (C)(1) to (C)(3) of this rule.

(1) When reclassification of hospitals among peer groups occurs as described in paragraph (B)(2) of rule 5101:3-2-072 of the Administrative Code, the peer group average cost per discharge component will be redetermined if such redetermination would result in at least a two per cent difference, negative or positive, in the peer group average cost per discharge amount.

(2) The peer group average cost per discharge component will be redetermined if the use of revised or corrected hospital-specific average cost per discharge data would result in at least a two per cent difference in the peer group average cost per discharge amount subject to the provisions of this paragraph. In order to redetermine the peer group average cost per discharge under the provisions of this paragraph and paragraph (C) of this rule, the following conditions apply:

(a) Revised or corrected hospital-specific average cost per discharge data are identified under the provisions described in paragraphs (C) to (C)(3) of this rule, rule 5101:3-2-0712, or paragraphs (D) to (D)(3) of rule 5101:3-2-24 of the Administrative Code.

(b) Data described in paragraph (C)(2)(a) of this rule is identified within two rate periods following implementation of rebased rate components.

(3) For the purposes of paragraphs (C)(1) and (C)(2) of this rule, any redeterminations of the peer group average cost per discharge component will be made in accordance with the provisions set forth in rule 5101:3-2-074 of the Administrative Code. If peer group rates are subject to redetermination because they meet the provision of paragraph (C)(1) or (C)(2) of this rule, the timing of the adjustment to the rate and the mechanism for retrospectively adjusting previously paid

claims depends upon the magnitude of the adjustment. If the use of revised hospital-specific data for one or more hospitals in a peer group results in a change of at least five per cent in the peer group average cost per discharge, the rate adjustment will be made prospectively for admissions on or after the thirtieth day following the final administrative decision described in rule 5101:3-2-0712 of the Administrative Code, or following the recognition by the department that an adjustment in the peer group average cost per discharge calculation is warranted, whichever is earlier. Claims previously paid that are subject to the adjustment will be adjusted retrospectively at interim settlement or can be mass adjusted if the provider requests in writing that a mass adjustment of that provider's claims be performed. If the use of revised data for one or more hospitals in a peer group results in a change of less than five per cent in the peer group average cost per discharge, the adjustment will be made prospectively for admissions on or after the first day of the next rate year and retrospectively during interim or final settlement. The retrospective adjustment of previously paid claims will be accomplished by determining the difference between the amount paid during the period that incorrect rates were in effect and the amount that would have been paid if the correct rates had been in effect AND ADJUSTING THIS AMOUNT BY CASE-MIX.

(D) Redetermination of the a hospital-specific rate component.

Redetermination of a hospital-specific rate component as described in rules 5101:3-2-075 to 5101:3-2-077 of the Administrative Code will not be implemented until the beginning of the next prospective rate year unless the need for the change in the rate component is detected within the first ninety days of a new rate year. Adjustments to claims paid during a period when a rate component was incorrect will be made retrospectively at interim settlement. Corrections to these rate components will be made prospectively at the beginning of the following rate year.

(E) Notification of effective rates.

Prior to the beginning of each prospective payment rate year, each Ohio hospital will be given notice regarding payment rates for the upcoming prospective payment years. The payment rate information described in this paragraph will be effective for the prospective payment year, except as otherwise provided in rules 5101:3-2-0712 and 5101:3-2-24 of the Administrative Code and this rule. Information provided in the notice described in this paragraph shall include:

(1) Peer group average cost per discharge adjusted as described in rule 5101:3-2-074 of the Administrative Code;

(2) Hospital-specific allowances, as applicable, for capital, medical education, and disproportionate-share as described in rules 5101:3-2-074 to 5101:3-2-077 of the Administrative Code;

(3) Hospital-specific case mix factor, as described in rule 5101:3-2-074 of the Administrative Code; and

(4) Indication of whether the hospital is recognized as operating a distinct-part psychiatric unit, and/or level I, II, or III nursery unit as each are described in rule 5101:3-2-02 of the Administrative Code. Hospitals must notify the department immediately when a change in psychiatric unit distinct part and/or nursery unit occurs. Retrospective adjustment of previously paid claims to reflect the change in status of the psychiatric unit or nursery will be processed for claims with discharges beginning on the later of the effective date of the change or the first day of the rate year in which the department was notified of the change. No adjustments to paid claims will be made for claims with discharge dates that were prior to the beginning of the rate year in which the department was notified of the change.

EFFECTIVE DATE:_____

CERTIFICATION: _____

_____
DATE

Promulgated Under RC Chapter 119.

Statutory Authority RC Section 5111.02

Rule Amplifies RC Section 5111.01 and 5111.02

Prior Effective Dates: 10/1/84, 7/8/85, 7/3/86, 10/19/87, 2/1/89, 7/1/90

TNS # 91-13
SUPERSEDES
TNS # 90-39

APPROVAL DATE 11-21-91
EFFECTIVE DATE 9/4/91
3

5101:3-2-079 Payment for outliers.

This rule defines day and cost outliers, exceptional outliers, and describes the reimbursement methodology that will be used in paying for all types of outliers FOR INPATIENT HOSPITALS SUBJECT TO THE PROSPECTIVE PAYMENT SYSTEM.

(A) ODHS will provide for an additional payment to a hospital for covered inpatient hospital services to a medicaid recipient which exceeds the thresholds as described in paragraphs (A)(1) to (A)(7) of this rule.

(1) For DRGs 1 to 350; 352 to 384; 391 to 455; 457 to 468; 471 to 490: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by two standard deviations as specified by ODHS. For DRG 351, the threshold is five days.

(2) For DRGs 388 to 390 and 492 to 498: The recipient's covered length of stay exceeds the statewide geometric mean length of stay for the applicable DRG by one standard deviation as specified by ODHS.

(3) For DRGs 1 to 350; 352 to 384; 391 to 468; 471 to 490: The cost for an inpatient stay exceeds the statewide arithmetic mean cost, for the applicable DRG by two standard deviations, OR FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, THE TOTAL ALLOWED CHARGES FOR AN INPATIENT STAY EXCEEDS THE STATEWIDE ARITHMETIC MEAN CHARGE FOR THE APPROPRIATE DRG BY TWO STANDARD DEVIATIONS. Effective October 19, 1987, the threshold for DRG 351 is three thousand seventy-seven dollars and seventy-five cents.

For prospective payment periods, subsequent to October 19, 1987, the threshold described in this paragraph for DRG 351 is inflated to the prospective payment period as described in rule 5101:3-2-074 of the Administrative Code except that for the rate year beginning with July 1, 1990, the inflation factor used is not adjusted to account for changes in outlier payment policy.

(4) For DRGs 385; 388 to 390; 492 to 498: The cost for an inpatient stay exceeds the statewide arithmetic mean cost, for the applicable DRG by one standard deviation, ~~.~~ OR FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, THE TOTAL ALLOWED CHARGES FOR THE INPATIENT STAY EXCEEDS THE STATEWIDE ARITHMETIC MEAN CHANGE FOR THE APPLICABLE DRG BY ONE STANDARD DEVIATION.

(5) If a hospital that does not meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule has a discharge that qualifies for both a day and cost outlier payment, then the hospital receives payment for the case as a day outlier only, except for DRGs 385; 456; 388; 389; and 492 to 498. For discharges on or after October 19, 1987, DRGs 385 and 456 qualify for cost outlier payments only.

For discharges on or after July 1, 1989, DRGs 388; 389; and 492 to 498 qualify for cost outlier payments only. Outlier payments for cases in hospitals that do meet the criteria described in paragraphs (E)(1) and (E)(2) of this rule and that qualify for both a day and a cost outlier payment are as described in paragraphs (A)(5)(a) and (A)(5)(b) of this rule.

(a) For discharges prior to February 1, 1988, the policies described in paragraph (A)(5) of this rule apply.

(b) For discharges on or after February 1, 1988, a case in any DRG that qualifies for both a day and a cost outlier payment will be paid as a cost outlier only.

(6) If a hospital that meets the criteria described in paragraph (G) of this rule has a discharge that groups into DRG 488, DRG 489, or DRG 490 that qualifies for both a day and cost outlier payment, then the hospital receives payment for the case as a cost outlier only.

(7) If the cost for a case determined by multiplying the allowed charges from the claim by the hospital-specific cost-to-charge ratio, determined in accordance with the provisions of paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code, exceeds two hundred fifty thousand dollars, then payment will be as described in paragraph (D) of this rule.

(B) Payment for extended length of stay (day outliers).

(1) If the hospital stay reflected by a discharge includes covered days of care beyond the threshold as described in paragraphs (A)(1) and (A)(2) of this rule, an additional payment shall be made.

(2) Any case which qualifies for a day outlier payment is subject to review as described in rule 5101:3-2-0713 of the Administrative Code.

(3) For discharges in DRGs 1 to 350; 352 to 384; 391 to 468; 471 to 490: Except as provided in paragraph (B)(5) of this rule the per diem payment made under paragraph (A)(1) of this rule will be based on sixty per cent of the per diem, except that for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, per diem payment made under paragraph (A)(1) of this rule will be eighty per cent of the per diem for discharges on or after February 1, 1988. The per diem is calculated by dividing the hospital's final prospective rate for that DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG.

For DRG 351 the mean length of stay is 1.6.

The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem amount. The total payment is the final prospective payment rate as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(4) For DRGs 388 to 390 and 492 to 498: The per diem payment made under paragraph (A)(2) of this rule will be based on eighty per cent of the per diem determined by dividing the hospital's final prospective payment rate for that DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier

payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem amount. The total payment is the final prospective payment rate as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(5) If a hospital meeting the criteria described in paragraph (G) of this rule has a discharge that groups into DRG 488, DRG 489, or DRG 490, the per diem payments made under paragraph (A)(1) of this rule will be based on eighty per cent of the per diem for discharges on or after SEPTEMBER 3, 1991 ~~the effective date of this rule~~. The per diem is calculated by dividing the hospital's final prospective rate for that DRG as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, less capital and teaching allowance for the applicable DRG by the statewide geometric mean length of stay, calculated excluding outliers, for that DRG. The total day outlier payment is then determined by multiplying the number of covered days beyond the day threshold times the per diem amount. The total payment is the final prospective payment rate as determined in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, plus the outlier payment. If the total payment exceeds allowable charges, reimbursement is limited to allowable charges.

(C) Payment for extraordinary high-cost cases (cost outliers).

(1) IF THE ALLOWABLE COST EXCEEDS THE STATEWIDE COST THRESHOLD FOR THE APPLICABLE DRG AS DESCRIBED IN PARAGRAPHS (A)(3) AND (A)(4) OF THIS RULE, AN ADDITIONAL PAYMENT SHALL BE MADE. FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, IF THE ALLOWABLE CHARGES EXCEEDS THE STATEWIDE CHARGE THRESHOLD FOR THE APPLICABLE DRG AS DESCRIBED IN PARAGRAPHS (A)(3) AND (A)(4) OF THIS RULE, AN ADDITIONAL PAYMENT SHALL BE MADE.

~~If the allowable cost for a discharge exceeds the statewide cost threshold for the applicable DRG as described in paragraphs (A)(3) and (A)(4) of this rule, an additional payment shall be made.~~

(2) Any case which qualifies for a cost outlier payment is subject to review as described in rule 5101:3-2-0713 of the Administrative Code.

(3) For discharges in DRGs 1 to 384; 391 to 468; 471 to 490: Except as otherwise provided in paragraph (C)(6) of this rule the difference determined by subtracting the statewide cost threshold OR STATEWIDE CHARGE THRESHOLD FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, as described in paragraph (A)(3) of this rule from the allowable costs OR ALLOWABLE CHARGES FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, is multiplied by sixty per cent to determine the additional payment to be made for the outlier portion, except that for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, the multiplier is eighty per cent for discharges on or after February 1, 1988 and before July 1, 1990. For discharges for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule that occur on or after July 1, 1990, payment will be in accordance with paragraph (C)(5) of this rule. The total payment for cost outlier claims except those described in paragraph (C)(5) of this rule is the final prospective payment rate as described in paragraph (I) of rule 5101:3-2-074 of the Administrative Code, plus the outlier amount.

For discharges on or after October 19, 1987, if the total payment exceeds allowable charges, reimbursement is limited to allowable charges. For discharges on or after July 1, 1990, total reimbursement is limited to the lower of allowable claim charges or claim cost. Claim cost is calculated by multiplying allowable claim charges by the hospital specific, medicaid inpatient cost-to-charge ratio, as described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code.

(4) For DRGs 385, 388 to 390, and 492 to 498: The difference determined by subtracting the statewide cost threshold OR STATEWIDE CHARGE THRESHOLD FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, as described in paragraph (A)(4) of this rule from the allowable cost, OR ALLOWABLE CHARGES FOR DISCHARGES ON OR AFTER THE EFFECTIVE DATE OF THIS RULE, is multiplied by eighty per cent to determine the additional payment to be made for the outlier portion except that for discharges on or after July 1, 1990, for hospitals meeting the criteria described in paragraphs (E)(1) and (E)(2) of this rule, payment will be in accordance with paragraph (C)(5) of this rule. The total payment for cost outlier claims except those described in paragraph